Stay Well @ Home Service

Presented by:
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Stay Well @ Home Team - Who are we:

• A multidisciplinary hospital based team of:
  - Occupational Therapists
  - Physiotherapists
  - Assistant Therapy Technicians
  - Social Workers

• Teams operating across both DGH’s (Royal Glamorgan Hospital, Llantrisant & Prince Charles Hospital, Merthyr Tydfil)

• 7 day service – working between the hours of 08:00 – 20:00
What do we do:

Primary Focus
The primary roles of SW@H are:
• To identify individuals at risk of admission who can be returned home sooner with the appropriate community support.
• Where an admission takes place, the SW@HT aim to support an earlier discharge

A&E Response -
• SW@HT aim to respond to A&E referrals within one hour
• SW@HT look to prevent admission to AMU at the point of A&E by working alongside medical and nursing colleagues
• Triggers for SW@HT involvement:
  – Falls (past/present)
  – Acute changes to mobility (as a result of an acute injury or illness)
  – Concerns with coping at home
  – Difficulties managing everyday activities (as a result of an acute injury or illness)

AMU/CDU Response –
• SW@HT attend bed management & Daily AMU board rounds with seniors nurses
• SW@HT aim to support people in returning home to reduce length of stay and unnecessary transfer to an acute ward

SW@HT Ward Response –
• Work alongside MDT on the wards to support people in returning home in a timely fashion who require packages of care
Why do we do it:

- To provide a joined up/integrated way of working across health, social care and third sector to improve service users experience and outcomes

- To ensure that there is a rapid response infrastructure built around the hospital based team to provide the required level of support in the community in a timely manner

- The service was developed around the needs of the older person to avoid unnecessary admissions to hospital and delays in transfers of care

- To provide an alternative option to a hospital bed

& most important of all....
Improve the quality of care provided by Health, Social Care and Third Sector services by working together
How do we do it:

Case Examples
What is the difference:

• A person can now have an assessment outside of core hours – 365 days a year, 8am – 8pm

• SW@HT use agile working devices to conduct assessments anywhere in the hospital

• Information is shared across health & social care, using one assessment, shared by all professionals/trusted assessors in the team

• Care and support packages are agreed and arranged within the agreed 4 hour response – 7 days a week, including bank holidays

• Discharge to assess model

• Community review undertaken within the first 14 days to establish any ongoing needs

• An enabling approach is implemented to increase independence levels and reduce dependence on long term service provision
What this means to our service users:

- Support provided in the right place at the right time
- People do not have unnecessary hospital stays
- Voice & Control – people at the centre of the assessment and are actively involved in the discharge planning
Measures of success:

“What a fantastic service, especially as my Mother came home on a bank holiday, which we never thought would happen.”

“Thank you for taking the time to listen, I now feel that my Mother will get the support she needs and my Father will start accepting support at home. The experience has turned from a negative, from coming into hospital after my Mother fell, to actually having a positive impact on my Mother and Father’s care and support.”

“Thank you for getting me home, I can sleep in my own bed tonight.”
Thank you for listening

Any questions

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